CITY OF SAN ANTONIO

Human Resources Department
P. O. BOX 839966
SAN ANTONIO TEXAS 78283-3966

DOMESTIC PARTNERSHIP

Tax Dependent Status Form

I. INSTRUCTIONS

Before you enroll your domestic partner and/or domestic partner's child(ren) for health benefit coverage, be prepared to indicate whether your domestic partner and/or his or her child(ren) are your tax dependent(s) for federal income tax purposes. Use this form to indicate whether or not your domestic partner qualifies as your tax dependent under the Internal Revenue Code. Because the Human Resources Department cannot provide tax advice, seek help from your personal tax advisor if you have questions.

II. TAX DEPENDENT STATUS

If your domestic partner and/or his/her or child(ren) qualify as your tax dependent(s), as that term is defined by the Internal Revenue Code , then you may pay for your portion of health benefit premiums with pre-tax dollars. Furthermore, the portion of the premiums paid by the City of San Antonio will not be considered taxable income to you. Finally, you may also be able to utilize your flexible spending account for their health and /or dependent care expenses.

If your domestic partner and/or your domestic partner's child(ren) do not qualify as your tax dependent(s) for federal income tax purposes, then you must pay for their portion of health benefit premiums with after-tax dollars. Furthermore, the portion of the premiums paid by the City of San Antonio for coverage of your domestic partner and/or his or her child(ren) will be included in your gross income and subject to applicable payroll taxes. Finally, you will not be able to be utilize your flexible spending account for their health and/or dependent care expenses.

If you fail to indicate the federal income tax status of your domestic partner and/or your domestic partner's children, the City of San Antonio will treat your domestic partner and/or domestic partner's children as not qualifying as your tax dependent(s) for federal income tax purposes.

III. TAX STATUS SELECTON

Please indicate on the reverse side of this form whether or not your domestic partner qualifies as your "dependent" for federal income tax purposes, as that term is defined under the Internal Revenue Code.

You should consult with your own personal tax advisor before you verify that your domestic partner and/or your domestic partner's child(ren) are dependents as defined by the Internal Revenue Code.

Prepared by City of San Antonio Employee Benefits Division
10/09/2013

CITY OF SAN ANTONIO

Human Resources Department
SAN ANTONIO TEXAS 78283-3966

AFFIDAVIT of DOMESTIC PARTNERS

AFFIANTS: (COSA Employee) _____
(Domestic Partner) _____

Affiants make the following statements under oath:

- We are domestic partners who meet the requirements for medical and/or dental plans offered by the City of San Antonio;
- We have been living together for at least 6 months;
- Both partners are at least eighteen years of age;
- Both partners are each other's sole domestic partner;
- Neither partner is married to anyone else;
- We are not related by blood or marriage ;
- We are committed to each other and consider each other jointly responsible for each other's common welfare; and
- We are not in the relationship solely for the purpose of obtaining benefits coverage.

We understand that the City may ask us to produce documents or other proof that we meet or continue to meet the above conditions and we agree to promptly provide such documentation or proof.

We agree that if our relationship changes so that we no longer meet the above conditions, the Employee/Retiree will provide written notice of that change to Benefits Division of the City of San Antonio Human Resources Department within thirty-one (31) days of the date of change.

This Affidavit is submitted to the City of San Antonio specifically to qualify the Domestic Partner for the coverage under the medical and/or dental plans offered by the City of San Antonio with the understanding that the eligibility of Domestic Partner for such benefits depends on the truthfulness of our statements in this Affidavit.

We understand that knowingly providing misinformation in this document will result in disciplinary action against the Employee, and the City may recover from either or both the Employee/Retiree and the Domestic Partner, all costs incurred by the City related to benefit coverage for the Domestic Partner.

Each of us swear and affirm that we have read this document, that these statements are true and correct, that we understand the content and importance of these statements and that, in consideration of the City's provision of benefit coverage for the Domestic Partner, we agree to abide by the provisions of this statement and affidavit.

_____ _____

Employee/Retiree Signature Date

_____

Employee/Retiree Social Security Number

SWORN AND SUBSCRIBED before me on _____, 201____by _____.

_____

Notary Public
Commission Expires_____

_____ _____

Domestic Partner Signature Date

_____

Domestic Partner Social Security Number

SWORN AND SUBSCRIBED before me on _____, 201___ by _____.

_____

Notary Public
Commission expires: _____

Prepared by City of San Antonio Employee Benefits Division
10/09/2013

CITY OF SAN ANTONIO
Human Resources Department
SAN ANTONIO TEXAS 78283-3966

Domestic Partner Tax Dependent Status

Check the box that applies.

Is your domestic partner your "dependent" as that term is defined by the Internal Revenue Code and its regulations and as that term is modified for purposes of coverage under accident or health plans under Internal Revenue Code?

☐ **YES**

☐ **NO**

Children of the Domestic Partner Tax Dependent Status

Is the child(ren) of your domestic partner, who you intend to cover, your "dependent(s)" as that term is defined by the Internal Revenue Code?

☐ **YES**

☐ **NO**

IV. SIGNATURE

I understand that the declarations I have made herein have legal and financial implications and that, before signing this document, I should seek advice from my personal tax advisor. I agree to reimburse the City of San Antonio for any and all liability including, but not limited to, taxes, penalties, or losses, that the City of San Antonio may incur due to its reliance on the statements I have made on this form. I agree to notify the City of San Antonio on the prescribed form , within thirty-one days, if there is any change in my domestic partner status which may make my domestic partner no longer eligible for benefits or if there is any change in the partner's dependent status for federal income tax purposes.

_____ _____

Employee/Retiree Signature Date

_____ _____

Domestic Partner Signature Date

Prepared by City of San Antonio Employee Benefits Division
10/09/2013

2012 Domestic Partner Medical Coverage
Taxable Income and Incremental Costs

Employees applying for domestic partner benefits should be aware that such benefits have significant tax consequences. This statement is not intended as tax or legal advice but rather to alert employees of the potential tax ramifications.

You and the City of San Antonio share in the cost of covering a domestic partner and/or his/her eligible dependent children, the same as someone would for coverage of a spouse and their own eligible dependent children. However, there are additional financial and tax implications to consider with a domestic partner. The Internal Revenue Service (IRS) has determined that an employer's cost of providing benefits for a domestic partner and their children is considered "imputed income", which means it is subject to taxes.

The City must report on your W-2 form the fair market value of an employee's domestic partner benefits as wages or "imputed income" to the IRS, resulting in increased taxable gross income for federal income taxes. In addition, FICA (Social Security and Medicare) taxes will be withheld from your paycheck. The amount of this income depends upon the plan in which you are enrolled and the level of coverage.

The following is an example of the taxability of coverage if you are enrolled in the Value Plan and were hired before January 1, 2009. The payroll deduction amount to cover your domestic partner and/or your partner's child is a post tax deduction, unlike medical coverage for the enrolled family members.

Level of Coverage Under Value Plan - Pre-2009 Hire	Total Employee Deduction	EE Deduction portion that is Pre-Tax	EE Deduction Portion that is Post-Tax	Imputed Income*
Employee + Domestic Partner	$36.00	$3.50	$32.50	$64.58
Employee + Domestic Partner + Domestic Partner Child	$46.00	$3.50	$42.50	$127.17
Employee +Employee Child + Domestic Partner	$46.00	$9.00	$37.00	$60.08
Employee + Employee Child + Domestic Partner + Domestic Partner Child	$46.00	$3.50	$42.50	$127.17
Employee + Employee Child + Domestic Partner Child	$9.00	$3.50	$5.50	$67.10
Employee + Domestic Partner Child	$9.00	$3.50	$5.50	$67.10
Employee + Certified Domestic Partner** + Domestic Partner Child	$46.00	$36.00	$10.00	$62.60
Employee + Domestic Partner +Certified Domestic Partner Child** + Employee Child	$46.00	$9.00	$37.00	$60.08
Employee +Certified Domestic Partner** + Domestic Partner Child + Employee Child	$46.00	$36.00	$10.00	$62.60

Prepared by City of San Antonio Employee Benefits Division
10/09/2013

***Imputed Income –** Income separate from, and in addition to, your monthly plan cost. It is the City's contribution toward the additional coverage for your domestic partner and/or your partner's child. The imputed income is subject to federal tax withholding, Social Security tax and Medicare tax.

****Certified Domestic Partner or Certified Domestic Partner Child** – IRS indicates a domestic partner or partner's child can be considered a tax dependent if they meet certain criteria. The employee must certify the Domestic Partner and/or Domestic Partner Child are a tax dependent. A tax dependent is treated as a legal dependent and is not subject to imputed income.

If an employee considers certifying his or her partner as a tax dependent, consulting a tax advisor is recommended. Falsely certifying a tax dependent may result in charges of tax fraud by the IRS and disciplinary action by the City.

DISCLAIMER: The foregoing examples are for illustration only and may not reflect your actual circumstances. The City of San Antonio and its Human Resources Department are not providing you with tax advice or legal advice. You are urged to consult your own tax advisor(s) concerning the federal income tax and employment tax ramification from your enrolling your domestic partner or your partner's children in one of the City's sponsored plans.

CITY OF SAN ANTONIO - 2014 Civilian Benefit Enrollment Form

INITIAL ENROLLMENT ☐ OPEN ENROLLMENT ☐ BENEFITS CHANGE ☐

SECTION 1 – EMPLOYEE'S INFORMATION

Name:	Social Security No.:
Date of Birth:	SAP Number:
Daytime Phone Number(s):	

SECTION 2 – MEDICAL BENEFIT OPTIONS – Select plan and level of coverage.

☐ Consumer Choice ☐ New Value PPO ☐ Premier PPO ☐ Waive (see reverse side)	☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren)/Domestic Partner Child(ren) ☐ Employee + Spouse/Domestic Partner + Child(ren)/Domestic Partner Child(ren)

SECTION 3 – ADDITIONAL BENEFIT OPTIONS – Select plan and level of coverage.

☐ Delta Care DHMO (Delta Care form required) ☐ CitiDent PPO (Delta Dental)	☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren)/Domestic Partner Child(ren) ☐ Employee + Spouse/Domestic Partner + Child(ren)/Domestic Partner Child(ren)
☐ Vision (Davis)	☐ Employee Only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren)/Domestic Partner Child(ren) ☐ Employee + Spouse/Domestic Partner + Child(ren)/Domestic Partner Child(ren)
Dearborn National Additional Life Insurance	☐ 1X ☐ 2X ☐ 3X ☐ 4X ☐ 5X **As a new hire, Evidence of Insurability is required for Additional Life for 3X, 4X, or 5X annual base salary. During OE, any increase requires Evidence of Insurability.
Dependent Life Insurance	☐ YES ☐ NO
Additonal Long Term Disability (Increases from 40% to 60% of salary)	☐ YES ☐ NO
REIMBURSEMENT ACCOUNTS * Please provide the annual contribution amount. This amount will be divided by the remaining pay periods of the current year.*	Health Saving Acount: $ _____ (Consumer Choice Only) (Optum Health Bank Form Required. This form can be obtained at the Employee Benefits Office) Health Care Flexible Spending Account: $ _____ Child/Elder Care Flexible Spending Account: $ _____

List eligible family member(s) to be covered: Plan Codes: "M" For Medical "D" For Dental "V" For Vision
Relationship Codes: (1) Spouse (2) Dependent Child(ren) (3) Domestic Partner (4) Domestic Partner Child(ren)

Please attach copies of all required validation documents for each dependent (i.e., marriage/birth certificate)

First Name	Last Name	Birth Date	Relation Code	Social Security	Gender	Plan	Add/Drop Dependent
					☐M ☐F	☐M ☐D ☐V	☐Add ☐Drop
					☐M ☐F	☐M ☐D ☐V	☐Add ☐Drop
					☐M ☐F	☐M ☐D ☐V	☐Add ☐Drop
					☐M ☐F	☐M ☐D ☐V	☐Add ☐Drop
					☐M ☐F	☐M ☐D ☐V	☐Add ☐Drop

TOBACCO USER CERTIFICATION

• Tobacco products include but are not limited to: cigarettes, cigars, pipes, all forms of smokeless tobacco (chewing tobacco, snuff, dip or any other product that contains tobacco), clove cigarettes or any other smoking devices that use tobacco such as hookahs. E-cigarettes which contain nicotine are also included.

• "Tobacco User" is defined by the City of San Antonio as a person who has used tobacco products within the past sixty (60) days.

• It is my obligation to submit an amended certification if I declare to be a Non-Tobacco User and become a Tobacco User, by resubmission of the required form through the Employee Benefits Division.

• **I understand that $40 monthly fee is the surcharge amount that I will be obligated to pay if I acknowledge that I am a Tobacco User.**

• I understand that all surcharges as a Tobacco User will be prospective, and will not be refunded if I become a Non-Tobacco User. However, if I subsequently cease to be a Tobacco User, I may submit an amended certification changing my status from a Tobacco User to Non-Tobacco User. Once this amended certification is processed future surcharges will cease for the duration of my Non-Tobacco user status.

• I understand that if I submit a certification changing from a Tobacco User to a Non-Tobacco User, I must also present a certificate of completion from a qualified Tobacco Cessation Program or medical physician.

• By making my election below, I acknowledge that I have read the above Tobacco User Certification information, understand it, and certify my election as accurate.

☐ I am **NOT** a tobacco user ☐ I am a tobacco user

WAIVER OF HEALTH COVERAGE

I understand that if I decline enrollment now and have no other health insurance coverage, I will be liable for any and all health care liabilities incurred due to this lapse in coverage.

Please provide other carrier information:

Carrier Name:_____

Policy Number:_____

I understand that once an employee has waived coverage, no changes can be made during the year until the next annual open enrollment period, unless there is a legal change in family status.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31days after the marriage, birth, adoption, or placement for adoption.

ACKNOWLEDGEMENT

I have read the 2014 Benefits Guide. I hereby make my election of benefits for 2014 and understand that my elections cannot be changed unless I incur a qualifying life change (i.e. newborn, adoption, marriage, divorce). The change can be made at the Human Resources Employee Benefits Office or through my Human Resources Specialist and only within 31 calendar days of a qualifying life change.

I have read the above information and authorize payroll deductions that may result from my elections and tobacco certification. I swear or affirm that the information I have provided for the purpose of receiving health benefit coverage is true and correct, and I understand that knowingly providing false information may result in loss of coverage, discipline, and criminal prosecution.

Please check here to certify your benefit selections:

☐ I agree with the 2014 benefits selections and authorize bi-weekly payroll deductions in the amount of the reflected premium selected as well as a monthly $40.00 tobacco surcharge if I am a tobacco user. Tobacco Surcharge is only applicable to employees certifying as tobacco users. I authorize premium deductions, in the form of payroll deduction from my bi-weekly paycheck, in the amount of any unpaid premium that may occur during any nonpay status once my pay resumes to prevent plan cancellation.

Employee Signature:_____ **Date:** _____

Office Use Only:	**Proccessed**	**Pending**	**Other**	**Verified By**

Prepared by City of San Antonio Employee Benefits Division
10/09/2013

CITY OF SAN ANTONIO - Uniform Benefit Enrollment Form

INITIAL ENROLLMENT ☐ OPEN ENROLLMENT ☐ BENEFITS CHANGE ☐

SECTION 1 – EMPLOYEE'S INFORMATION

Please print, and complete all areas.

Name:	**Social Security No.:**
Date of Birth:	**SAP Number:**
Phone Number(s):	**Email:**
Mailing Address:	**Apt #:**
City, State, Zip:	

SECTION 2 – MEDICAL BENEFIT OPTIONS

Select level of coverage and answer questions 1 and 2.

CitiMed Police	**Employee Only**	☐	**Employee +1**	☐	**Employee +2 or more** ☐
CitiMed Fire	**Employee Only**	☐	**Employee +1**	☐	**Employee +2 or more** ☐

☐ **Opt-Out Medical**

SECTION 3 – DEPENDENT PLAN COVERAGE **Relation Codes: (1) Spouse (2) Dependent Child(ren) (3) Domestic Partner (4) Domestic Child(ren)**

First Name	Last Name	Birth Date	Relation Code	Social Security	Gender	Add/Drop Dependent
					☐M ☐F	☐Add ☐Drop
					☐M ☐F	☐Add ☐Drop
					☐M ☐F	☐Add ☐Drop
					☐M ☐F	☐Add ☐Drop
					☐M ☐F	☐Add ☐Drop
					☐M ☐F	☐Add ☐Drop

ACKNOWLEDGEMENT

I have read the Collective Bargaining Agreement explaining the City of San Antonio Benefits Program. I hereby make my election of benefits for 2014 and understand that my election cannot be changed once this form is received by the Employee Benefits Division. This change may only be made in person at Human Resources within 31 days of a qualifying live event. (i.e., newborn, marriage, divorce, death, etc.)

I swear or affirm that the information I have provided above for the purpose of receiving health benefit coverage is true and correct; and I understand that knowingly providing false information may result in loss of coverage, discipline, and criminal prosecution.

Employee Signature: _____ **Date:** _____

Office Use Only:	Process	Pend	Other	Verified by